UNITED
NATIONS

E

Economic and Social
Council

Distr.
GENERAL

E/CN.4/AC.45/1994/6/Add.1
10 October 1994

Original: ENGLISH

COMMISSION ON HUMAN RIGHTS
Working Group on the Right
to Development
Third session
3-14 October 1994

Report of the Secretary-General submitted in accordance with Commission on Human Rights resolution 1994/21

Addendum

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GE.94-14468 (E)

Introduction

1. In addition to the replies received pursuant to the letter of the Secretary-General dated 26 April 1994, which are contained in document E/CN.4/AC.45/1994/6, replies have been received from the United Nations Children's Fund (18 July 1994), the United Nations High Commissioner for Refugees (25 July 1994) and the World Health Organization (8 August 1994). Tne present report has been prepared on the basis of those replies.

I. REPLIES RECEIVED FROM UNITED NATIONS BODIES

UNITED NATIONS CHILDREN'S FUND

2. The United Nations Children's Fund submitted the following documents to the Working Group on the Right to Development:

Introduction to the Progress of Nations, UNICEF, 1994;

Chapter 2 of the State of the World's Children, UNICEF 1994;

"Environment and Development, Children First", UNICEF;

"Accelerating Progress for Africa's Children", Message by J.P. Grant, 1992;

"Accelerating Human Development in the 1990s", Address by R. Jolly, 1993;

Donor Commitments to Children: a review of official development assistance for 20/20 and human development priorities, UNICEF Executive Board Paper (E/ICEF/1994/CPR.38).

The documents are available for consultation in the Secretariat's files.

UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES

3. The humanitarian mandate of the High Commissioner to protect and assist refugees also includes a statutory responsibility to seek permanent solutions to the problems of refugees. Over the last few years, UNHCR has increasingly been called upon to act in countries of origin to facilitate durable solutions to refugee problems and, whenever feasible, prevent the recurrence of such problems. This has brought the humanitarian functions of UNHCR closer to the development dimensions of humanitarian concerns.

4. The sustainability of solutions to refugee problems to a large extent relies on the maintenance of peace and security, the restoration of the rule of law, the recovery of development opportunities and the respect of human rights in the countries of origin of the displaced. In order to meet the needs of reintegrating returning refugees and other displaced persons, when conditions allow them to move back in safety to their areas of habitual residence, UNHCR has developed new modalities of humanitarian assistance,

referred to as QIPs (quick impact projects). UNHCR enclosed the working draft for a Policy and Methodological Framework for Quick Impact Projects (QIPs) which can be consulted in the Secretariat's files.

II. REPLIES RECEIVED FROM SPECIALIZED AGENCIES

WORLD HEALTH ORGANIZATION

5. The World Health Organization took the opportunity to express its commitment to the letter and the spirit of the Declaration on the Right to Development. It furthermore submitted the following information, based on the submissions of its various divisions.

Division of Emergency and Humanitarian Action (EHA)

6. Disaster means acute interruption of the development in the disaster-hit area. The individual and collective right to health and development is adversely affected by emergencies. EHA has been operating or planning to operate in 33 countries. Most of them are located in the African continent. While disasters are negatively affecting development by draining resources necessary for development, underdevelopment is increasing the disaster vulnerability of these countries. To ensure the right to development in the health sector, disaster prevention, reduction and preparedness should be built into the developmental plan of the country. This includes early warning.

7. WHO emergency and humanitarian action aims at the urgent provision of essential health care for the disaster-affected population. This takes place in order that the right to health may continue to be pursued within the broader framework of Health for All and as part of the right to development.

8. The implementation of WHO's emergency and humanitarian actions is undertaken in such a way that development objectives are promoted. This has been the policy of WHO since EHA Division was established in 1989. Therefore, WHO has implemented health emergency programmes through community participation, local capacity-building and human development policy. This way, the right to development is preserved during the implementation of emergency and humanitarian action. In addition, the transition from relief to development assistance is ensured.

9. WHO realizes the importance of building the logistical capacity necessary both for humanitarian relief actions and for long-term development (road reconstruction, communications, establishment of regional stocks and distribution centres). In addition, the trans-sectorial character of health that includes housing, nutrition, security, environment, water and sanitation, health education, immunization and mother and child care, etc. implies a close collaboration between WHO and the national authorities and, in complex emergencies, with other United Nations organizations and NGOs. The same intersectoral cooperation necessary to implement the primary health care strategy in pursuing development is translated into an inter-agency emergency approach in disaster relief.

10. Following armed conflicts, the right to development is reasserted. WHO is active, together with other United Nations agencies, in providing the

health components of demobilization of soldiers in Mozambique and in reintegration of ex-combatants in the health system in Eritrea. WHO's action strengthens the peace process and facilitates development.

11. Although the WHO response to complex emergencies is increasingly coordinated with other United Nations agencies within the DHA-led Inter-Agency Consolidated Appeal Process (CAP), further coordination is needed beyond the launching of the CAP, as well as in disaster early warning, prevention, mitigation and preparedness. Donors' response to rehabilitation activities must also be facilitated.

Division of Environmental Health

12. The United Nations Conference on Environment and Development (UNCED) highlighted the need for a development process that does not jeopardize future generations. Among the first principles emerging from the Conference was that human beings are at the centre of concerns for sustainable development, and that the right to development must be fulfilled so as to meet equitably the developmental and environmental needs of present and future generations. The emphasis on sustainability, the concern for the individual, both at present and in the future, and the call for equity in development planning clearly correspond to Commission resolution 1994/21 and place adequate environmental quality within the context of a "human right"; a condition which all persons should be able to expect as a normal condition of his/her existence.

13. The main impact of environment on people is on their health, be it beneficial or detrimental. Therefore, since development impinges on the environment, its impact on health has to be a primary consideration. The position of the World Health Organization concerning the status of health as a basic human right is clearly spelt out in its Constitution: "Health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". In this context health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

14. UNCED recognized the linkages of development and health within the framework of a sustainable environment, and as such included in "Agenda 21" a chapter on health, "Chapter 6 - Protection and Promotion of Human Health". In this chapter the intimate interconnection of health and development is stressed in so far as insufficient development can lead to poverty and inappropriate development can result in overconsumption. Coupled with an expanding world population, this can result in severe environmental health problems in both developing and developed nations. Health ultimately depends on the ability to manage successfully the interaction between the physical, spiritual, biological and economic/social environment. Sound sustainable development, which is accepted as a "human right", is not possible without a healthy population; however, most developmental activities affect the environment to some degree, which in turn causes or exacerbates many health problems. Conversely, it is the very lack of development that adversely affects the health condition of many people, which can be alleviated only through development.

15. The health sector cannot meet basic needs and objectives on its own; it is dependent on social, economic and spiritual development, while directly contributing to such development. In particular, attention should be directed towards food safety, comprehensive and sustainable water policies to ensure safe drinking water and sanitation to preclude both microbial and chemical contamination of water and food. Measures should also be taken to protect the atmosphere to ensure that the air breathed does not result in adverse health consequences. In addition, it should be ensured that people are not exposed to the risks from excessive radiation from the sun resulting from depletion of the ozone layer and other damage to the atmosphere, or from health risks arising from global warming.

16. The WHO Commission on Health and Environment, appointed by the Director-General of WHO as a fully independent body in early 1990, underscored that the maintenance and improvement of health should be at the centre of concern about the environment and development, bearing in mind that the most immediate problems in the world are ill-health and premature death caused by biological agents in the human environment; in water, food, air and soil. These problems are shared by both developed and developing countries.

17. Accepting that development is a "human right", it is a requirement of health that the global cycles and systems on which all life depends are sustained in the planning and implementation of development strategies.

18. In summary, accepting that development is a "human right", that development cannot take place without some modifications to the environment, and that human health, the primary consideration, is dependent on the environment, a basic component of any planning and/or strategy to satisfy this "right" must contain health as an integral component. The "rights" to development and the right to health are interdependent, with the environment forming the linkage. They therefore have to be planned for together if the needs of both are to be satisfied. Also, development not only relates to improvements in economic terms but must include improvement in the conditions of the environment, the reduction in risks to the environment and the improvement in health status resulting from the environmental improvements and safeguards. The environment not only impacts on physical health but clean air, aesthetic surroundings and a lack of excessive noise are also beneficial in reducing stress, creating well-being and increasing life expectancy, all important criteria of quality of life.

Global Programme on AIDS

19. The existence and continuing spread of HIV/AIDS affects individuals, communities and States at every level of society and impinges directly on the right to development in three ways. First, the socio-economic effects of the epidemic may prevent States from achieving the right to development, that is, from achieving the enjoyment of "economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realized", (article 1, Declaration on the Right to Development). Though the socio-economic impact of HIV/AIDS cannot be fully described here, it is clear that the social and economic impact of AIDS in some communities and States will be devastating and will hinder the realization of the right to development.

20. The widespread stigmatization and discrimination experienced by people living with HIV/AIDS deny these individuals, and often their families, the enjoyment of many of the critical aspects of the right to development. Such discrimination and stigmatization can be seen in legislation, administrative practice, and community and individual responses. For persons living with HIV/AIDS, this discrimination includes denial of employment, education, housing, freedom of movement and the right to privacy, as well as access to health care and support. In this context, HIV/AIDS and related discrimination impair the full enjoyment of the right to development for people living with HIV/AIDS, which under article 8 of the relevant Declaration entails, inter alia, equal opportunity for both individuals and groups with regard to access to "basic resources, education, health services, food, housing, employment and the fair distribution of income". Women, who often already function under social, economic and political disadvantages and in some places represent 50 per cent of those living with HIV/AIDS, are even less able to avail themselves of the means by which to avoid infection and/or achieve the necessary support and care for themselves or affected family members.

21. Thirdly, not only does the HIV/AIDS epidemic retard realization of the right to development for States, communities and individuals, but the obverse is also true - failure to implement the right to development retards efforts at all levels to combat the disease. This is because, without development, States, communities and individuals do not have the tools necessary to slow the spread of the disease. These tools include access to health care, education, information, economic opportunity and protection of human rights. Lack of education and information creates difficulties when devising educational information programmes for the prevention of HIV infection. Lack of government resources and poverty limit access to health care services, condoms and needed medication. Lack of economic opportunity and protection of human rights reduce choices in terms of avoiding infection and having appropriate means for care when infected.

Division of Health Promotion and Education

22. Health is a fundamental human right. Health is also a strong component of development, both as an essential condition and as a basic consequence of development action. Therefore, most expressions referring to the right to development automatically imply the right to health. From the Health Promotion and Education angle a number of constraints continue to prevent specific population groups from fully enjoying the right to health and development.

23. There is still a lack of awareness and/or understanding, mainly among decision-makers and local leaders, of health as a human right and of the interactions between health and development. This may be one of the major reasons which prevented strengthening of programmes and structures concerned with promoting health and preventing disease.

24. People have the right to know and learn about health issues and problems. However, there is still insufficient dissemination of pertinent information on health to individuals, families, communities and to society as a whole. There is also a lack of continuous mobilization of social forces and social organizations in favour of health.

25. The right to essential health services and health knowledge implies the development of well-designed comprehensive school health promotion and education programmes in favour of school-age children and youth, both in and out of school. By the year 2000, 150 million children in the age group 6-11 years and 301 million in the age group 12-17 years will be out of school, and thus deprived of the right to know and possess skills to act for health. Along with these children must be added the adults who are illiterate - 905 million adults were illiterate in 1990 of whom 587 million (65 per cent) were women. Of course, this does not include the many others who are functionally illiterate.

26. Experience shows that the educational status of women is a crucial factor for shaping the health behaviour of herself, her children and her family. A major constraint is illiteracy among women and the neglect of the female child in receiving schooling.

27. The right to health and development, as well as the right to know about health, calls for sustained processes of involving concerned communities, social organizations, leaders and individuals in all phases of planning, implementing, monitoring and evaluating health and development projects, from their early planning stage. This is not always the case due to various political, economic and social reasons, especially an excessive centralization of administrative and financial power.

28. Millions of people in both developing and developed countries are deprived of the right to health-supportive environments - which includes physical, social and economic dimensions. Most often, these are brought about by development activities that ignore the damage to the environment. People have the right to live and work in places and environments that are safe and that do not adversely affect their health and well-being. A combination of a lack of knowledge, skills and a supportive environment leads to disease and unhealthy lifestyles. On the other hand, unemployment has negative effects on the physical, mental and social health of individuals, families and communities.

29. All population groups, including vulnerable groups, have the right to "health security". The elderly have the right to age in good health. Unfortunately, in many instances the increasing cost of health and social services, the breakdown of family ties, the insufficient income of the aged and various armed conflicts deprive many aged population groups from the right to health and from continuing their voluntary contribution to development action.

30. Disabled and handicapped people have a right to live with dignity, having access to rehabilitation services and social integration.

31. Patients with diseases that have social stigma such as leprosy and HIV/AIDS have the right to proper treatment and care and the right to be respected. Discrimination against the sick because of their inability to pay, because of the nature of the disease they suffer from, or because of ethnic reasons is another constraint to health development.

32. A strong advocacy action for health and development is still needed to address decision-makers, opinion leaders, influential social groups, professional groups and leading economic forces, using all available media and pertinent communication channels throughout society.

Division of Development of Human Resources for Health

33. WHO has long given priority to the careful development of human resources for health. Health workers represent the largest portion of the budget (60-80 per cent) and with good planning, training and management and an appropriate balance between the different categories they can make a major contribution to the health of a nation. Often, however, health personnel are in the wrong proportions to each other, in the wrong geographic locations or in inappropriate types of institutions. Sometimes they spend too much time on activities that make a limited contribution to health. Moreover, many countries have trained more health workers, or a higher proportion of the more expensive categories, than their economies can support. Therefore, we must try to achieve an optimal number and mix of professional categories at specific levels of service, each with well-demarcated roles and responsibilities, yet closely interacting in a coordinated team approach.

34. In the politicized and competitive society of today, a new concept of public health must be defined beyond the narrow epidemiological basis to complex multisectoral interactions. New basic competencies remain to be identified in such a new milieu.

35. Imbalances, particularly in inappropriate skills-mix and the maldistribution of health personnel, exist in many countries. However, the health professions alone have not been responsible for the imbalances. Society in general has contributed to them, simply because people have been unaware of, or have ignored, their negative effects. The number of physicians to 100,000 population ranges from 2 to 475, and of nurses from 2 to 1,372; doctor/nurse ratios vary from 1:0.5 to 1:16.4. There is no discernible pattern which reflects the socio-economic or health situation of countries that report these statistics. What does this mean for the attainment of Health for All, or even the provision of minimum essential services?

36. Scientific and technical developments, diversification in patterns of health care delivery and the overriding concerns about the cost will require radical departures from traditional roles of the different health professionals, as well as the ways in which they are trained.

Division of Intensified Cooperation with Countries

37. The right to development is inherent in the strategy of intensified WHO cooperation with countries and peoples in greatest need (IWC). This strategy is country-focused and country-specific - in contrast to WHO's more usual programmatic approach - and is aimed at the poorest of the poor - the poorest countries and the poorest groups within those countries.

38. IWC thus aims to combat and lessen inequities in the health system, especially as these affect disadvantaged groups such as women, children, the elderly, migrant workers, etc. Particular emphasis is placed on the links

between poverty and health and poverty-alleviation schemes are encouraged, such as small credit schemes, involving income generation, linked with health conditionalities.

39. A basic component of this approach is to assist countries in health policy reform, formulation and implementation. Decentralization policies are supported, concentrating more on the peripheral levels of the health system and to empower local groups to build up their own capacities to participate actively in the development of the local community.

40. Health legislation has been a valuable tool for institutionalizing these reforms, ensuring the right of people to development and health.

41. The aim is to develop not mere passive involvement, but rather a sense of ownership of the local health system and, through the intersectoral connections necessary for this, a pride and belief in the capacity of the community to develop itself. This capacity for development, nurtured and encouraged at the grass-roots level, has flow-on effects on higher levels of the system.

42. To ensure close and effective coordination in this approach, IWC has built up active partnerships with other United Nations agencies and bilateral development agencies to support specific activities at local and country levels. These partnerships are important, especially in countries facing great social inequities and even violations of human rights, where pressures from the international community towards improving equity could facilitate significant changes.

Maternal and Child Health and Family Planning

43. Human development is both the foundation and the objective of social development. Ill-health has been seen as a drain on individual and social development in so far as resources are diverted from other development needs and illness reduces the full potential of individuals and populations to contribute their physical and creative energies to social development. Health and social development can be seen from the perspective of either resource consumption or human capacitation. Furthermore, the health and the medical paradigms present two distinct perspectives vis-à-vis social development. By primarily addressing disease and medical care far higher investments are required in medical care while the survival achieved is no guarantee of uncompromised human development potential. In general, addressing the human development needs through health promotion and disease prevention are less costly and more effective in the long run.

44. The health problems of women and children have their origins in the inherently vulnerable stages of the cycle of reproduction, growth, development and maturation. Failure to meet the growth and development needs at one stage adversely affects subsequent stages. At no stage is this vulnerability greater and its lifelong impact so profound for both mother and infant as during pregnancy, delivery and the immediate postpartum period. For the newborn infant we can speak of the critical days, even minutes, that establish the individual's quality of life.

45. To a great extent the physical and intellectual capacity of adults to contribute to the social, economic and cultural development of their societies begins even before conception in the health and well-being of the future and potential mother. Unequal access to health care and food, excessive work at times of rapid growth, denial of equal opportunity for education and obstacles to reproductive health leave a woman physically, socially and mentally unable to exercise her full rights to personal and social development, unable to protect herself from unwanted pregnancies or sexually transmitted diseases.

46. Newborn health and the reproductive health needs of women are inseparable. Both are deeply embedded in the social patterns of marriage, the expectations of child bearing and the competing productive and reproductive demands on women. It is the inequitable application of these factors that undermine the nutritional status of woman, her ability to choose when and how often to bear children and her ability to use and obtain quality care during pregnancy delivery, or on the occasion of other reproductive health needs. Anaemia, micronutrient deficiency and a lack of essential fatty acids are linked to a high incidence of low birth weight, which in turn represents a major factor contributing to subsequent infant mortality and morbidity.

47. Low birth weight is the weak link for child survival and development. It is the end result of a lifetime of ill health, malnutrition, chronic parasitic infections, and overwork, smoking and infections during pregnancy. Both during the newborn period and then into infancy and childhood the low-birth-weight infant is at much higher risk of mortality and severe morbidity than full-term, full-sized infants. Compared to full-term infants, they have a three to four times greater risk of dying from diarrhoeal diseases, acute respiratory infections and, if not immunized, measles. They are more likely to be malnourished at one year of age. And, by the age of four or five years, the low-birth-weight child, more likely to be suffering the cycle of infection and malnutrition, will be severely stunted. Its growth deficiency will be borne into adult life and be translated into reduced work output, and often impaired learning ability. Brain damage from birth trauma, asphyxia and/or hypothermia greatly increase these risks, particularly among very-low-birth-weight infants.

48. Failure to prevent or treat the health problems encountered during pregnancy and delivery will also affect the child's subsequent growth, physical and mental abilities and school performance. This places an increased burden and strain on the family, the community and various social institutions and denies the full potential contribution of the child as an adult.

49. Child labour and its relationship to health is another example of a health barrier to the right to social development. Despite the very limited research in the field, most evidence supports the view that exploitative child labour takes a serious toll on the health and psycho-social development of children. An analysis of the officially reported mortality data from countries suggests that a working child has at least a four times greater risk of dying from a machinery-associated injury than a child of 15-19. In a study in Malaysia, working children had a six times greater rate of hospitalization than comparable non-working children. These children are at increased risk of injury, illness, disablement and death because of their increased

vulnerability during growth and mental development. They are using tools designed for adults that result in greater risks of fatigue, injury and death. They have smaller lungs, breath more rapidly and therefore are exposed to higher concentrations of airborne particles and toxic substances. Because the respiratory tract of children is much more narrow than that of the adult, it is more likely to suffer permanent damage and to then be at high risk, as an adult, of premature death from chronic lung disease.

50. When the health hazards of child labour are compounded by inadequate nutrition, including anaemia, the damage to health and development is increased manyfold, and is often permanent. If the child who has just enough calories to grow is expending his or her energy on work output instead, that child will become stunted and will have a diminished capacity for work as an adult. For each 10 kilograms of weight that a child fails to gain in growing to its expected adult weight, there will be a 10 per cent lower work output when compared with an adult whose childhood was not scarred by undernutrition and having had to divert growth energy into work output.

Programme on Substance Abuse

51. Problems related to psychoactive substance use (PSU) may impede the full realization of the right to development due to the following circumstances:

(a) Management of PSU may infringe on universal human rights through inadequate punishment, torture, exploitation, discrimination, stigmatization and denial of access to health care. The immediate consequence of such a situation has been that psychoactive substance users are forced into clandestine lifestyles, with the appalling results of the spread of AIDS, crime and further marginalization;

(b) PSU may affect the right to development because of the Governments' support to licit drugs promotion, production and consumption, where they are sources of revenue, despite the well-known fact that every year 3 million people die prematurely because of tobacco smoking-related diseases, and another 1 million yearly deaths are caused by alcohol intake;

(c) PSU affects the realization of the right of development also because of the irrational assignment of huge resources for the "war against drugs" in developing countries and for eradicating some plants, while only token money is invested by the international community on both supporting drug demand and promoting programmes that recognize that "The human person is the central subject of development and should be the active participant and beneficiary of the right to development". On the other hand, because of military interventions and the use of herbicides against the poorest farmers - those who cultivate illicit plants for survival and have no alternative sources of income - many developing countries are trapped in a situation which increases the contrast between rural and urban areas and is not at all favourable to the entitlement of all persons "to participate in, contribute to, and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realized".

Division of Strengthening of Health Services

52. The basis of world health policy is social justice. Clearly, if this is not respected, there will be no development. The right to health preceded the World Conference on Human Rights and it is now universally recognized that equity and basic human needs must remain the primary concern of social development strategy. The wide disparities in living conditions and in opportunities must be reduced, with special attention to rural areas and urban slums. The critical needs of special groups - such as children and young people, women with their particular disadvantages, the elderly and the disabled - require added emphasis.

53. The first three essential elements of primary health care as defined in the Declaration of Alma-Ata are education, food and proper nutrition, and an adequate supply of safe water and basic sanitation. In most countries the health sector can do little on its own in these areas.

54. The importance of coordinated efforts by the social and economic sectors is clear. Those making decisions on economic policy must be informed of the implications of their policy for the health and social conditions of the various population groups.

55. The relationship between health status and socio-economic development has been amply demonstrated. In developed countries, the communicable diseases that were once the principal causes of mortality were controlled by improvements in living conditions, nutritional status, sanitation and health behaviour, and this was done before major discoveries were made regarding their cure and treatment. In the low-income countries, health development became part of the national economic strategy, which sought to provide the poor with access to resources and economic opportunities, raise educational levels, ensure the availability and distribution of food, improve the status of women, and provide the basic infrastructure of transport and other public amenities.

56. While the primary responsibility for achieving health goals is with the health sector and its agencies, a share of the responsibility devolves on other sectors. The past decade has seen the evolution of a wide variety of mechanisms for promoting intersectoral action. However, the conventional chain of command and organizational structure of ministries and government offices are strongly protective of departmental boundaries and therefore have built-in biases against intersectoral coordination and are not naturally responsive to objectives outside their sphere of authority. Therefore, these mechanisms for the most part did not foster the dialogue on common issues, or identify the joint action required, or formulate common goals.

57. There is an increasing recognition at the international level that institutional changes, social welfare policies targeted at vulnerable population groups and priority areas such as nutrition, and measures to make income distribution less unequal can have a much greater impact on social welfare and social progress than an expansion in output. In choosing an approach to human resource and institutional development in accordance with national priorities, values, traditions, customs and stage of development, special attention has to be given to education and health; they are essential

aspects of human resource development. At the special session of the United Nations General Assembly devoted to international cooperation in April 1990, considerable agreement was reached on the fundamental goals and strategies for the Fourth United Nations Development Decade and also on major international economic policy questions. At the start of the 1900s, the General Assembly saw an opportunity to restore a long-term approach to development, moving beyond short-term adjustments and focusing on the primary objective of the betterment of the human condition by responding to the needs of and maximizing the potential of all members of society. Fresh approaches to the formulation and implementation of health, nutrition, housing, population and other social welfare policies as a key to both improving individual welfare and successful development have been called for at national and international levels.

58. In the Declaration of Alma-Ata inequities in the health status of the people were identified as a common concern of all countries:

> "The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries" (Declaration of Alma-Ata (3)).

59. Governments must take the lead in formulating equity-based health policies and strategies. In developing health policies, it is important to distinguish between differences in health and health care. Reduction of differences in health status requires broad-based government action involving all sectors. Government macroeconomic adjustment policies, stabilization programmes and pricing reforms have important effects on the health of the underprivileged. Measures needed for health care improvement lie within the mandate of the health sectors. Specific effective strategies for improving the health of the underprivileged have included: the provision of cash and food subsidies to families; the creation of employment opportunities; the augmentation of educational opportunities, particularly for women; improved access to essential health care; and the promotion of healthy lifestyles. Policies should establish targets for the improvements of the health of underprivileged groups. WHO's European Regional Office has considerable experience in the development of such indicators.

60. The wisdom of transferring resources to the poor is a matter of controversy. Experience shows that such a policy is crucial to ensure that the underprivileged do not have to wait for resources to "trickle down". On the other hand, the danger exists that where two programmes are in place, one for the poor and one for the rich, the one for the former is likely to be second rate.

61. Equity-based financing aims at ensuring that underprivileged population groups are not excluded from health care for economic reasons. Firstly, resources should preferably be allocated according to need rather than for services actually delivered. Secondly, prepaid health plans, including national health insurance, by removing economic barriers at the time of use of services, are more accessible to underprivileged populations. Cost recovery

and other privatization reforms of the health system, unless carefully designed and monitored, may end up excluding large numbers of poor people.

62. Involvement of the underprivileged in the effort to improve their own health is crucial. Given that poverty discourages cooperation and encourages a primary commitment to self and family, what strategies can be used to inform and mobilize the poor? Schools in underprivileged areas may be an entry point. What participatory methods and approaches could be adopted? What links should be established with NGOs and grass-roots organizations? How can governmental and other agencies support efforts at the local level? These questions remain to be answered.

63. A challenge faced by many countries is how to safeguard health and health care for the underprivileged in adverse circumstances, such as the adoption of economic adjustment policies. It is essential for ministries of health (and the ministries dealing with other sectors) to identify essential services which the Government should fund as a priority. The most effective use possible should be made of existing manpower, which represents the most costly component of the recurrent budget. Retraining and redeployment may be necessary. Finally, inequities in health and health care must be brought from obscurity into the spotlight of national debate.

64. For most industrial and many developing countries, the challenge is one of political will. For the 33 countries that have been bypassed and left behind by the health-for-all movement, special support is needed. The emphasis should be on mobilizing additional resources for them and supporting them to learn from each other.

65. The biggest challenge in future is to develop a partnership between individuals, communities, districts, countries, and the global community. The partnership has to be actively developed; it cannot be taken for granted.

66. Finally, there remain two crucial issues - reaching the underprivileged in the pursuit of greater equality and making renewed attempts to raise the quality and effectiveness of health care.